

Spravato (esketamine) nasal spray**Member and Medication Information (required)**

Member ID:	Member Name:	
DOB:	Weight:	
Medication Name/ Strength:	Dose:	
Directions for use:		
Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:
All information to be legible, complete and correct or form will be returned. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992		

Criteria for Approval (all of the following criteria must be met):

- ☐ Diagnosis of treatment-resistant depression managed by or in consultation with a psychiatrist or mental health professional.
- ☐ Appropriate trial and failure (due to lack of effect or unacceptable adverse reactions) of at least two preferred antidepressants with different mechanisms of action:
Medication used: _____ Medication used: _____
Duration of use: _____ Duration of use: _____
Result: _____ Result: _____
- ☐ Use in conjunction with an oral antidepressant:
Current medication, dose, duration of therapy: _____
- ☐ Plan to monitor and manage "black box" warnings of sedation, disassociation, abuse and misuse, and suicidal thoughts and behaviors.
- ☐ Plan to administer the spray in a health care setting and under the supervision of a health care provider, to observe the patient for at least 2 hours after administration, and to not allow driving or using heavy machinery for the rest of the day of administration.
- ☐ Healthcare setting is certified in the Spravato REMS program.
- ☐ Dispensing pharmacy is certified in the Spravato REMS program.
- ☐ Patient is 19 years of age or older.

Re-authorization Criteria:

Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Authorization: Up to three (3) months

Re-authorization: Up to six (6) months

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature

Date